TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Joshua Woody, M.D.

Respondent Name
Safety National Casualty Corporation

MFDR Tracking Number
M4-16-1733-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This code is for a work status report which is requested from the carrier. This code can't be bundled with the office visit."

Amount in Dispute: $15.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on March 1, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2015	Work Status Report (99080-73)	$15.00	$15.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5 defines the procedures for Work Status Reports.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 190 – Billing for report and/or record review exceeds reasonableness.
   - OA – The amount adjusted is due to bundling or unbundling of services.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the total reimbursement for the disputed service?
3. Is the requestor entitled to reimbursement for the disputed service?

Findings

1. The insurance carrier denied disputed services, in part, with claim adjustment reason code 190 – "BILLING FOR REPORT AND/OR RECORD REVIEW EXCEEDS REASONABLENESS." 28 Texas Administrative Code §129.5(d) requires the doctor to file a Work Status Report:

   (1) after the initial examination of the employee, regardless of the employee's work status;
   (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and
   (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee.

   Review of the submitted information finds that the insurance carrier did not support that the requirements of 28 Texas Administrative Code §129.5(d) were exceeded by the disputed service. Therefore, the insurance carrier's denial reason is not supported.

   The insurance carrier also denied disputed services, in part, with claim adjustment reason code OA – "The amount adjusted is due to bundling or unbundling of services." Review of the submitted documentation does not support this denial reason.

2. 28 Texas Administrative Code §129.5(i) states, in relevant part:

   > Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15.

   The division finds that the total reimbursement is $15.00.

3. The reimbursement amount for the disputed service is $15.00. The insurance carrier paid $0.00. A reimbursement of $15.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $15.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 12, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.